STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G606	A. BUILDING 01 B. WING	03/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	3025 GREENHILLS LN S INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 03/15/12 Facility Number: 001175 Provider Number: 15G606 AIM Number: 100245640 Surveyor: Mark Caraher, Life Safety Code Specialist, At this Life Safety Code survey, REM-Indiana, Inc. was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story building with a basement was determined to be fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, bedrooms and all living areas. The facility has a capacity of 8 and had a census of 7 at the time of this survey.	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 1.9. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/22/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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KS018	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Doors are provided with latches or other mechanisms suitable for keeping the doors closed. No doors are arranged to prevent the occupant from closing the door. 32.2.3.6.3, 32.2.3.6.4, 33.2.3.6.3, 33.2.3.6.4 Doors are self-closing or automatic closing in accordance with 7.2.1.8 Exception: Door closing devices are not required in buildings protected throughout by an approved automatic sprinkler system in accordance with 32.2.3.5.1 and 33.2.3.5.2. Based on observation and interview, the facility failed to ensure 1 of 1 basement sleeping room doors would close and latch into the door frame. This deficient practice could affect 1 of 7 clients in the facility. Findings include: Based on observation with the Direct Services Provider (DSP) during a tour of the facility from 12:20 p.m. to 12:55 p.m. on 03/15/12, a television cable from a wall plate in the basement bedroom was run along the floor from the bedroom through the doorway into a television in the basement activities room. The television cable did not allow the bedroom door to close and latch into the door frame. Based on interview at the	KS018	The Area Director called the cable company and they will be coming to the home to rerun the TV cable. The Home Manager will be retrained on completing the weekly Home Manager checklist to ensure that all maintenance needs will be addressed. The Home Manager will also be retrained on addressing maintenance issues and who to report them to, to ensure that they are completed. Ongoing, the Program Director will complete random audits of the home to ensure that all maintenance issues are completed when addressed. Completion Date: April 14, 2012 Responsible Party: Home Manager and Program Director	04/14/2012

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	time of observation, the DSP acknowledged the television cable prevented the bedroom door from latching into the door frame.			

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KS051	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD A manual fire alarm system is provided in accordance with Section 9.6, 33.2.3.4.1. Exception No 1: Where there are interconnected smoke detectors meeting the requirements of 33.2.3.4.3 and there is not less than one manual fire alarm box per floor arranged to continuously sound the smoke detector alarms. Exception No. 2: Other manually activated continuously sounding alarms acceptable to the authority having jurisdiction. Based on observation and interview, the facility failed to ensure 1 of 8 smoke detectors connected to the fire alarm system, was properly separated from an air supply. LSC 9.6.1.4 requires fire alarm systems to be installed, tested, and maintained in accordance with NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires, in spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect all occupants. Findings include: Based on observation with the Direct Services Provider (DSP) during a tour of the facility from 12:20 p.m. to 12:55 p.m. on 03/15/12, a smoke detector in the living room was located 12 inches from a ceiling fan. Based on interview at the	KS051	The ceiling fan in the living room was removed and replaced with a light on 3-19-2012. Ongoing, Indiana MENTOR Maintenance will ensure that no smoke detectors are located within 12 inches from any air flow device. Responsible Party: Indiana MENTOR Maintenance Completion Date: April 14, 2012	04/14/2012

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	time of observation, the DSP acknowledged the living room smoke detector was located 12 inches from a ceiling fan which could impede the function of the smoke detector.			

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KS152	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD (1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to - (i) Ensure that all personnel on all shifts are trained to perform assigned tasks; (ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. (2) The facility must - (i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities: (iii) File a report and evaluation on each drill: (iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and (v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. (3) Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. Based on record review and interview, the facility failed to provide documentation of fire drills conducted for 2 of 3 shifts for 2 of 4 quarters. This deficient practice affects all clients and staff. Findings include: Based on review of "Fire Drill Report" documentation at the Corporate Office	KS152	The fire drill schedule for 2012 was written so that drills each month are scheduled in more varied time frames that the previous 2011 schedule. The Home Manager and Program Director will ensure staff run all 2012 fire drills and that they are completed per the 2012 schedule monthly which will ensure the drills on all shifts are varied in time frame.	04/14/2012

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	with the Area Director during record review from 9:30 a.m. to 10:10 a.m. on 03/15/12, documentation was not available for review for a fire drill conducted on the first shift in the second quarter of 2011 or for the third shift in the fourth quarter in 2011. Based on interview at the time of record review, the Area Director acknowledged there is no documentation available for review of a fire drill being conducted on the first shift in the second quarter of 2011 or for the third shift in the fourth quarter in 2011.		Responsible Party: Program Director and Home Manger Completion Date: 4-3-2012	